POST-GRADUATE TRAINING PROGRAM APPLICATION
Occupational Medicine Residency Program
Department of Internal Medicine

University of South Florida College of Medicine
Affiliated Hospitals Program
13201 Bruce B. Downs Blvd., MDC Box 56
Tampa, Florida 33612-3805

POSITION APPLYING FOR _____ TO BEGIN _____ 20_____

PERSONAL DATA:

Name _____ **M.D. or D.O**. (please circle)
Last First Middle Maiden

Social Security No. ___ - ___ - ____ Citizen of _____

Birthplace City: _____ State _____

Country _____

Present Address _____ --
Number Street **Apt #**

Email _____ Telephone No. _____

City _____ State _____ Zip _____ Country _____

Person through whom you can always be contacted:

Name _____ Relationship _____

Address _____
Number Street City State Zip

EDUCATION: List below in chronological order every college or university you have attended.

School	Location	Dates	Degree and Date Received

(Use back of page if necessary)

Post-Graduate Training Program Application (continued)

Medical School_____

Address_____

Year Graduated_____

APPLICANT, PLEASE NOTE: The following information will help provide the Departmental with accurate statistical data but will not be considered in connection with your application. Completion is optional.

GENDER: _____Male _____Female BIRTHDATE:_____/_____/_____

RACE OR NATIONAL ORIGIN:

_____Caucasian _____Asian/Asian American _____Arabic

_____Black _____Hispanic _____Indian/Pakistani

_____Native American/Alaskan Native _____Other (Please Designate)

PROFESSIONAL EXPERIENCES: (Attach extra sheet, if necessary)

Hospital/Program	Nature of Appointment	Dates

LICENSE: List biographical data, papers written or any item that will strengthen your application. (Attach extra sheet, if necessary).

Do you hold a valid state Medical License? YES or NO (circle)

State _____ Number _____

Please attach a 2X3 Photo:

INTEREST AREA(S): (Describe your possible future professional goals or interests, i.e., General Internal Medicine, Subspecialties of Medicine, Other Practice, Field).

PERSONAL REFERENCES: (List names and addresses). The individuals listed below have been asked to submit personal references in support of my application.

Name	Address	City, State, Zip
Name	Address	City, State, Zip
Name	Address	City, State, Zip

I certify that the information given in this application is accurate and complete and to the best of my knowledge and understanding that falsification of information will be sufficient grounds for refusal of admission or for dismissal. If admitted to the University of South Florida, College of Medicine Post-Graduate Training Program, I hereby agree to abide by the policies of the Boards of Regents and the rules and regulations of the University of South Florida, College of Medicine.

Applicant Signature **Date** **20**

Notice to ALL APPLICANTS for Residency or Fellowship at the University of South Florida College of Medicine.

The purpose of this notice is to inform you that:

1. You will be required to submit a form to the Florida Board of Medicine that requires disclosure of information regarding
    a. all training and employment since graduating from medical school,
    b. any deviation or extension of your curriculum in medical school
    c. any probation or termination during medical school or prior residency
    d. any denial or termination of licensure
    e. termination of employment for any reason
    f. during the past 5 years, enrollment/mandate/participation in an alcohol or addiction program
    g. during the past 5 years, treatment for an addiction
    h. during the past 5 years, treatment for mental disorder or impairment
    i. during the past 5 years, treatment of recurrence of physical impairment
    j. being charged for acts related to the use or misuse of drugs, alcohol, or other substances
    k. being convicted of, pleaded guilty, nolo contendere or no contest to a crime in any jurisdiction other than minor traffic offense, even if adjudication withheld
    l. DUI charges and/or adjudication
    m. being under investigation in any jurisdiction for acts that could result in disciplinary action
2. You will be subject to an extensive, formal criminal background check
3. Some affiliated institutions require drug and alcohol screening prior to beginning rotations
4. If you falsify information to the Board of Medicine, this is a breach of your resident contract that requires you to assure state licensure/registration and your contract will be invalidated, revoked, rescinded and or your appointment as a resident will terminate.

If you perceive that providing honest information to these questions would subject you to unfair consideration, please contact Peter J. Fabri MD, Associate Dean for GME to confidentially discuss your concerns.

Acknowledged _____ Date _____

UNIVERSITY OF SOUTH FLORIDA, COLLEGES OF PUBLIC HEALTH AND MEDICINE, SUNSHINE EDUCATION AND RESEARCH CENTER
OCCUPATIONAL MEDICINE RESIDENCY PROGRAM
APPLICATION REQUIREMENTS CHECKLIST

You must have all of the following requirements, pertinent to your specific background, prior to having your file reviewed for the interview process for acceptance into the program. Please provide the following information:

____ Completed Post-Graduate Training Program APPLICATION.
- Please ensure that all proper boxes have been checked off and all questions are answered completely. Do not write "see resume or CV" – fill in application completely.
- If you do not know the answer to a question, please provide a written explanation.
- If you have applied for the program before and are applying again, please fill out a new application form for the year you are applying.

____ CURRICULUM VITAE (CV) or RESUME.
- If you have applied for the program before and are applying again, please provide an up-to-date CV or Resume.

____ A PERSONAL STATEMENT.
- This statement should describe why you would like to pursue occupational medicine and be approximately one (1) typed page in length.

____ LETTERS OF RECOMMENDATION (3 originals preferred).
- These three (3) original letters should be addressed to Dr. Stuart Brooks, Director of the Occupational Medicine Residency.
- If you have applied for the program before and are applying again, please provide three current (within the last year) letters of recommendation.

____ USMLE (Steps I, II, and III) ***or*** COMLEX-USA (Levels 1, 2, and 3) ***or*** FLEX SCORES **or** State License [see below] (copies).
- You must have all three steps of the USMLE or COMLEX-USA completed before you will be considered for the program. However, if you are waiting for the scores from a step, please indicate the date in which you took the step. Or, if you will be taking the third step between applying and the interview process, please let us know what date you will be taking the test.

____ MEDICAL SCHOOL DIPLOMA (copy).

____ OFFICIAL TRANSCRIPTS (original) to all academic institutions attended.
- If you are unable to get these transcripts for some reason, please send an explanation in writing to this office. You may fax this to (813) 974-4994 or email to traj@health.usf.edu You may forward copies of your transcripts until original and official transcripts can be sent.

____ STATE LICENSE(S) (copy each), if you are licensed in any state.

____ ECFMG CERTIFICATE (copy), if you are a foreign medical graduate.
- It is the policy of the American Board of Internal Medicine that graduates of International Medical Schools must hold a valid **indefinitely** ECFMG certificate in order to sit for any of the Certifying Examinations in Internal Medicine. Any questions regarding this policy, please contact (215) 386-5900.

____ PROOF OF CITIZENSHIP (copy). Visas or Passports, etc., are not USF-acceptable proof for this program. If you do not have your Permanent Resident Card "Green Card," you must be able to submit a valid work authorization form (card), and your social security card which shows "employment purposes only." Letters showing approval of your Application for Lawful Permanent Residence does not show proof. The following are the only types of citizenship proof accepted:
- International Citizens – Permanent Resident Card (Form I-551 – also known as "Green Card" or formerly known as Alien Registration Card).
- United States Citizens – Birth Certificate or Naturalization (Form N-550)

Resident Qualifications

Documentation Required

1. Completed Application
2. CV/Resume
3. Personal Statement
4. 3 Letters of recommendation
5. USMLE Steps 1, 2, & 3 or State License (not training license)
6. Medical School Diploma (copy)
7. Official Transcripts for bachelors, MD, and any graduate school
8. (originals-staple envelope to transcripts) Copies are ok until originals can be obtained.
9. State License - If they are licensed
10. ECFMG Certificate- Must have if foreign medical graduate
11. Proof of citizenship
    - Permanent Resident Card (green Card/ alien registration card)
    - Naturalization Form
    - Birth Certificate (if US born)
    - We cannot sponsor students on Visas

Must have at least 1 year US training (if US medical graduate)
Must have at least 2 years US training (if foreign medical graduate)